



# PARTOGRAM

Gravida (G): \_\_\_\_\_ Term (T): \_\_\_\_\_ Preterm (P): \_\_\_\_\_  
 Abortus (A): \_\_\_\_\_ Living Children (L): \_\_\_\_\_  
 Stillbirth (S): \_\_\_\_\_ Gestation: \_\_\_\_\_ weeks  
 Blood group/Rh: \_\_\_\_\_ Antibodies: \_\_\_\_\_  
 Date (YYYY/MON/DD)/time active labour established: \_\_\_\_\_  
 Date (YYYY/MON/DD)/time of membrane rupture: \_\_\_\_\_  
 Group B Strep positive?  Yes  No  Unknown

Birth Plan: \_\_\_\_\_ Support person(s): \_\_\_\_\_  
 Risk factors/concerns: \_\_\_\_\_

Date (YYYY/MON/DD)		Time												Vaginal Examination: % or cm long	
Hours	0	1	2	3	4	5	6	7	8	9	10	11	12		
Cervical Dilatation (+) Station (X)	9														
	-3	8													
	-2	7													
	-1	6													
	0	5													
	1	4													
	2	3													
	3	2													
		1													
		0													
Effacement															
Cx position															
Presenting part position															
Moulding/caput															
Amniotic fluid															
Blood/show															
Examiner															
<b>Cx Position:</b> (A) anterior, (M) mid, (P) posterior <b>Presenting Part Position:</b> (L) left or (R) right; (O) occiput or (Oth) other*; (A) anterior, (P) posterior or (T) transverse <b>Moulding/Caput:</b> (M) moulding (C) caput <b>Amniotic Fluid:</b> (Ø) absent, (Sc) scant, (Mod) moderate, or (L) large; (Cl) clear, (Bl) bloody, or (Mec) meconium present <b>Blood/Show:</b> (Sc) scant, (Mod) moderate, or (L) large															

### \*Document Medications on Medication Administration Record and Birth Record\*

Patient and Family Teaching					
Topic	Initials	Topic	Initials	Topic	Initials
Labour Progress		Induction/Augmentation		Second Stage of Labour	
Breathing/Relaxation Techniques		Birth Plan		Cesarean Birth	
Positioning for Labour and Birth		Pain Relief Options		Preterm Birth	
Third Stage of Labour		Infant Feeding		Baby Friendly Practices	

Signatures		
Print Name	Signature/Status	Initials



## PARTOGRAM Page \_\_\_\_\_ of \_\_\_\_\_

Date (YYYY/MON/DD)		Time													
Fetal Health Surveillance	Mode (IA or EFM *indication)														
	Rate (beats/minute)														
	Rhythm (IA: regular or irregular)														
	Variability (absent, min., mod., marked)														
	Accelerations (Yes or No)														
Decels (no, var., early, late, prolonged)															
Classification (Normal, Atyp, Abn)															
Contractions	Frequency (number in 10 minutes)														
	Duration (seconds)														
	Intensity (mild, mod., strong OR mmHg)														
	Resting tone (soft, firm OR mmHg)														
Oxytocin dose (mU/minute)															
<input type="checkbox"/> Augmentation <input type="checkbox"/> Induction started at _____ h. (Init.)															
Fresh Eyes (Initial)															
Blood pressure															
Temperature, Pulse, Respirations															
Oxygen Saturation															
Somnolence Score															
Patient Position															
Other (e.g. glucose, reflexes)															
Bladder assessment															
Regional Analgesia	<input type="checkbox"/> Epidural <input type="checkbox"/> Spinal <input type="checkbox"/> Combined <input type="checkbox"/> PCEA Bolus at _____ h. Continuous infusion at _____ h.														
	Dr.	Infusion Rate													
		Bolus (PCEA)													
		Dermatome at or below T4	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Bromage 4-6	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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